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Grassley, Colleagues Introduce Bill to Simplify Medicare's Bureaucracy

WASHINGTON – Sen. Chuck Grassley, ranking member of the Committee on Finance, Committee Chairman Max Baucus and Sens. Frank Murkowski and John Kerry today introduced legislation to improve the communication between Medicare and patients, doctors, and other health care professionals and to cut Medicare's bureaucracy.

"Medicare is a lifeline for millions of Americans," Grassley said. "Unfortunately, that line hits too many bureaucratic snags. Doctors and nurses spend much of their time on filling out paperwork instead of treating patients. They can't always get straight answers out of Washington. We need to streamline the system so Medicare works better for everyone."

The *Medicare Appeals, Regulatory and Contracting Improvements Act of 2001* builds on legislation introduced by Murkowski and Kerry earlier this year, as well as legislation pending in the House of Representatives.

Grassley said the measure responds to extensive complaints from Iowa health care workers that Medicare is plagued with bureaucratic problems. In addition to excessive paperwork, rules coming out of Washington are confusing and contradictory. Doctors and nurses may receive one answer to a question from their Medicare contractor and receive a different answer from Medicare headquarters in Baltimore.

The *Medicare Appeals, Regulatory and Contracting Improvements Act of 2001*:

- streamlines the issuance of regulations, providing a more reliable schedule of Medicare program changes for doctors, nurses and other health care professionals;
- offers additional, improved appeal rights for health care professionals;
- mandates enhanced education about Medicare program changes and updates for health care professionals;
- ensures that health care professionals receive straight answers from the Centers for Medicare and Medicaid Services about Medicare policies;
- updates Medicare's outdated contracting guidelines, bringing competition into the program so that the best available contractors will serve the program;
- provides incentives for contractors to give timely and accurate information to beneficiaries and health care professionals;
- and sets up two ombudsman programs -- one for beneficiaries and one for health care professionals -- so that confusion about policies may be clarified and recommendations made

on improving communication among all stakeholders.

Grassley said he took special care, throughout the development of the bill, to ensure that the legislation cuts bureaucracy without inviting health care fraud from any unscrupulous health care providers. The Office of the Inspector General of the Department of Health and Human Services, the General Accounting Office and the Department of Justice provided input during the process to achieve legislation that simplifies Medicare for providers while retaining the tools available to the federal government to fight program waste, fraud and abuse.

Key among those tools is the *False Claims Act*, Grassley said. Grassley is the co-author of the 1986 amendments to the *False Claims Act*. Those amendments strengthened the Act's qui tam, or whistleblower, provisions and gave federal prosecutors one of their most effective instruments against defrauding the government. Increasingly, the *False Claims Act* plays a significant role in the federal government's health care fraud prosecutions.

"Medicare is a public program," Grassley said. "Doctors and nurses know they have to account for every tax dollar they receive. They face the full weight of the law if they don't. In exchange for that accounting, Medicare owes them straight answers and efficient operations. That's a common-sense way to do business, and patients will profit from it."

Attachment: bill summary

The Medicare Appeals, Regulatory and Contracting Improvements Act of 2001
Sponsored by Senators Kerry, Murkowski, Baucus and Grassley
November 2001

Highlights:

- Relieves burdens on beneficiaries and providers by requiring the Centers for Medicare and Medicaid Services (CMS) to issue new rules and policies in an orderly and reasonable manner.

- Provides new appeal protections for all Medicare fee-for-service providers and beneficiaries.

- Requires CMS to use competition to select the best available administrative contractors to serve beneficiaries and providers.

- Requires the Medicare administrative contractors and CMS to place a greater emphasis on provider education and outreach.

- Reforms the Medicare overpayment collection and extrapolation process.

- Does not undermine the False Claims Act or current Medicare fraud enforcement efforts.

Title I–Regulatory Reform:

- Requires CMS to publish regulations on only one business day of each month.

- Prevents CMS from applying a new regulation or other policy decision until 30 days after the new policy has been issued.

Title II–Appeals Process Reform:

- Transfers administrative law judges (ALJs) whose sole responsibility is Medicare appeal cases from the Social Security Administration to HHS. Requires HHS to provide appropriate Medicare education and training to the transferred ALJs.

- Grants health care providers expedited access to judicial review of an appeal for a denied claim or provider determination involving a question of law or regulation.

- Requires CMS to expedite appeals of provider termination proceedings. Increases financial support for these appeals processes.

- Per the Administration's request, delays Sec. 521 and Sec.522 of the BIPA for one year. Strengthens Sec. 521 by establishing time frames for the new appeals process and setting standards for the newly created Qualified Independent Contractors (QICs).

- Requires CMS to establish new appeals procedures for providers which have had their enrollment (or re-enrollment) applications denied.

Title III–Contracting Reform:

- Permits the Secretary to enter into contracts with any entity eligible to serve as a Medicare contractor for one or more function.

- Requires that the Secretary use competitive procedures for contracting with Medicare administrative contractors.

- Limits the liability of administrative contractors, allowing for liability only in extraordinary circumstances. Allows the government to indemnify contractors for legal costs in most circumstances.

- Requires the Secretary to competitively bid all contracts by October 1, 2008.

Title IV–Education and Outreach Improvements:

- Increases funding for the Medicare Integrity Program (MIP) by $35 million annually beginning in 2003 to enhance provider education and training regarding billing, coding and other items to improve payment accuracy.

- Requires Medicare administrative contractors to provide general written responses in a clear, concise, and accurate manner within 45 days of receipt of the inquiries.

- Prohibits CMS from levying penalties or interest on providers which have reasonably relied on written guidance.

- Creates two new Medicare ombudsman programs for providers and beneficiaries to resolve unclear guidance and provide assistance to beneficiaries with respect to their complaints,

grievances, and requests for information.

- Requires CMS to establish a toll-free number that will transfer individuals with specific questions or seeking help to the appropriate entities.

Title V–Review, Recovery, and Enforcement Reform:

- Requires CMS to establish standards for random prepayment audits.

- Provides CMS more flexibility to enter into overpayment repayment plans.

- Prevents CMS from recovering overpayments until the second level of appeal is exhausted. If the ruling is ultimately reversed, CMS must repay the amount recouped with interest.

- Establishes a process for the correction of incomplete or missing data without pursuing the appeals process.

- Expands the current waiver of program exclusions in cases where the provider is a sole community physician or sole source of essential health care.

Title VI–Other Provisions:

- Prohibits the Secretary from asking questions relating to the Medicare Secondary Payer Act in the case of reference laboratory services if the Secretary does not impose such requirements for services furnished by independent laboratories.

- Clarifies current law to require that any emergency care services delivered to a Medicare fee-for-service beneficiary shall be covered by the Medicare program.

- Requires the Secretary to review the current cost-reporting requirements of hospitals and other providers and suppliers.

- Amends current-law hospice provisions to permit hospices to contract for services with other hospices for extraordinary, exigent, and other non-routine circumstances.

- Delays the Medicare+Choice lock-in provision by one year.

- Makes optional for home health agencies the collection and submission of OASIS data for non-Medicare and Medicaid patients pending a study by CMS on the application of OASIS to such patients.

- Authorizes a demonstration program to test the effectiveness of permitting Critical Access Hospitals that also operate non-inpatient services to be subject to a coordinated survey, rather than multiple surveys.